

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11359

11363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>604 Water</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H.</u> Middle <u>Unsabrish</u> Last		4. DATE OF DEATH <u>10/24/58</u> Month <u>10</u> Day <u>24</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/1889</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Water Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Unsabrish</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anne Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Ellen W. Unsabrish</u> Address <u>604 Water St. Harford, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC COR PULMONALE</u> DUE TO (c) <u>CHRONIC BRONCHIAL ASTHMA & Pulmonary Fibrosis - 10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>3 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY</u> , 19 <u>58</u> , to <u>October 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>OCTOBER 24</u> , 19 <u>58</u> , and that death occurred at <u>2:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D.		ADDRESS (Street, city or town, state) <u>200 N. UNION ST. BALTIMORE, MD.</u>	
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u>		DATE SIGNED <u>HARFORD, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/28/58</u>		22b. DATE THEREOF <u>Angel Hill</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford</u>		22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>OCT 31 '58</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD 11388 CERTIFICATE OF DEATH

DEATH CERTIFICATE

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DEATH CERTIFICATE

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CERTIFICATE OF DEATH

11360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belcamp</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BANDY, INFANT MALE</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER 28 19 58</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 27-1958</u>	9. AGE (In years lost birthday) yrs. <u>1</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>15 22</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL BANDY</u>				14. MOTHER'S MAIDEN NAME <u>MARION GRAVEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Carl Bandy, Belcamp, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS of NEWBORN</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>MB Normant MD</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>602 UNION AVE HARFORD, MD</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Oct. 31, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward R. McKenna Jr</u>				24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
ADDRESS <u>Abingdon, Maryland.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

11362

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

and District

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
Adrian, M. Lyland		Male		31		Oct. 31, 1928		Adrian, Maryland		Adrian, Maryland		Adrian, Maryland		United States of America	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
Oct. 31, 1958		Adrian, Maryland		Adrian, Maryland		Adrian, Maryland		United States of America		Cerebral hemorrhage		Natural		None	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT		REPORTED BY		TITLE		SIGNATURE	
Oct. 31, 1958		Adrian, Maryland		Adrian, Maryland		Adrian, Maryland		United States of America		Dr. J. H. Smith		Physician		[Signature]	
DATE OF ENTRY		PLACE OF ENTRY		CITY OF ENTRY		STATE OF ENTRY		COUNTRY OF ENTRY		ENTRY BY		TITLE		SIGNATURE	
Oct. 31, 1958		Adrian, Maryland		Adrian, Maryland		Adrian, Maryland		United States of America		[Signature]		Registrar		[Signature]	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11392

CERTIFICATE OF DEATH

11361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Rural				c. LENGTH OF STAY IN 1b 2 yrs.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Philip First Bordner Middle Emmorton Rd., Last				4. DATE OF DEATH Oct. 28 19 58 Month Oct. Day 28 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1885		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S. A.,	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-01-6158		17. INFORMANT Mrs., Anna Bordner, Edgewood, R.D., Maryland. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Congestive Heart Failure DUE TO (b) Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Primary lesion probably Gastric PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Plaster cast right foot Amputation 1/2 foot							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to Oct. , 19 58 , that I last saw the deceased alive on Oct. 28 , 19 58 , and that death occurred at 8 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 10-28-58							
ACTUAL SIGNATURE William A. Tyson M.D.				PHYSICIAN'S NAME (Type) William A. Tyson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Winters				24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

MASSACHUSETTS DEPARTMENT OF HEALTH DIVISION OF BIRTH RECORDS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

11362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		d. STREET ADDRESS <u>142 Bloomsbury Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stanley George Broadwater</u>		4. DATE OF DEATH Month Day Year <u>10/5/58</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chadron Printing Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md. Harre-de-Grace</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Broadwater</u>		14. MOTHER'S MAIDEN NAME <u>Grace Broadwater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Virginia M. Broadwater</u>		Address <u>142 Bloomsbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-5</u> , 19 <u>58</u> , to <u>10-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-5</u> , 19 <u>58</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Leuke</u>		ADDRESS (Street, city or town, state) <u>Harre-de-Grace Md.</u> DATE SIGNED <u>10/6/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Leuke</u>			
22. BURIAL, CREMATION, REMOVAL (Specify) <u>10/8/58</u>	22b. DATE THEREOF <u>10/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Addellows</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. H. H. H. H.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 8 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1363

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>NEW YORK, N.Y.</i>		5. DATE OF BIRTH <i>1910</i>		6. PLACE OF DEATH <i>BALTIMORE, MD.</i>	
7. OCCUPATION <i>CLERK</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>		9. MANNER OF DEATH <i>NATURAL</i>	
10. DATE OF DEATH <i>1955</i>		11. TIME OF DEATH <i>10:00 AM</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF REGISTRAR <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11366

CERTIFICATE OF DEATH

Reg. Dist. No.

11363

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase</u>				c. LENGTH OF STAY IN 1b <u>24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp</u>				d. STREET ADDRESS <u>128 Weber</u>			
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Coale</u> Last <u>Carr</u>				4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/1927</u>	9. AGE (In years lost birthday) yrs. <u>30</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Colicman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Harold Chase, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Naval Carr</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Coale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. 2</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Harold Chase, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>AIR EMBOLISM</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>10/29/</u> , 19 <u>58</u> to <u>10/22/</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/22/</u> , 19 <u>58</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. H. Wachsman, M.D.</u>				ADDRESS (Street, city or town, state) <u>407 S. UNION AVE</u> DATE SIGNED <u>10/24/58</u>			
PHYSICIAN'S NAME (Type) <u>Harold Chase, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10/25/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harold Chase, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home, Harold Chase, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 Film G235 10-24-58 et

11367 CERTIFICATE OF DEATH

11364

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY OR TOWN <u>BELAIR</u>		LENGTH OF STAY (in this place) <u>48 years</u>		CITY OR TOWN <u>BELAIR MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location) <u>202 Arch St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Ralph</u> (Middle) <u>I</u> (Last) <u>Cole</u>				<u>Oct 15</u> 19 <u>58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1897</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACADEMIC PRIVING JANITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C. (Maryland)</u>	
13. FATHER'S NAME <u>George W Cole</u>				14. MOTHER'S MAIDEN NAME <u>Isabell Kaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>217-07-2128</u>		17. INFORMANT & ADDRESS <u>01121a Cole</u> <u>202 Arch St Bel Air Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>CARDIO-RESP FAILURE</u>						<u>1/2 HR.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY OCCLUSION</u>						<u>6 HRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIO SCLEROTIC CARDIO VASC. DIS.</u>						<u>2 YRS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19..53, to....., 19..58, that I last saw the deceased alive on....., 19..58, and that death occurred at....., 3:12 P.M., from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. H. Adwell</u>				ADDRESS (Street, city, town, state) <u>40 Franklin Rd Bel Air Md</u>		DATE SIGNED <u>Oct 15 58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct 18-1958</u>		NAME OF CEMETERY OR CREMATORY <u>Hendon's Hill</u>		LOCATION (City, town, or county) (State) <u>Bel Air RD Md</u>	
24. REC'D BY REGISTRAR <u>OCT 20 1958</u>		REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Harte</u>		ADDRESS <u>Bel Air Md</u>	
DATE							

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11393

CERTIFICATE OF DEATH

11365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks Rural</u>		c. LENGTH OF STAY IN lb <u>1 year</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks Rural</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>Cutlip</u> Last <u>Cutlip</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10-1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Pete Cutlip</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Scott Rocks Md.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>232-24-2663</u>	17. INFORMANT <u>Mrs. Sarah Scott Rocks Md.</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia; Broncho; Pneumothorax</u> (Right) (Left) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Post CVA hemiplegia</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>12 Sept</u> , 19 <u>58</u> , to <u>17 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17 Oct</u> , 19 <u>58</u> , and that death occurred at <u>9:30 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>JARRETTVILLE, Md.</u> DATE SIGNED <u>—</u>					
ACTUAL SIGNATURE <u>Thos. A. E. Moseley, Jr.</u> M.D. <u>JARRETTVILLE, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Thos. A. E. MOSELEY, JR. M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Droop Church</u>		22d. LOCATION (City, town, or county)	(State) <u>W Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Kutz</u>		ADDRESS <u>Jarrettsville</u>		24a. REC'D BY REGISTRAR <u>OCT 24 58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

11393

11393

<p>NAME OF DECEASED <i>John A. Smith</i></p>		<p>DATE OF DEATH <i>Jan 15 1923</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>CITY <i>Baltimore</i></p>	
<p>STATE OF BIRTH <i>Maryland</i></p>		<p>COUNTY <i>Harford</i></p>	
<p>DATE OF BIRTH <i>Jan 15 1878</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>DATE OF INTERMENT <i>Jan 17 1923</i></p>		<p>TIME OF INTERMENT <i>11:00 AM</i></p>	
<p>PLACE OF INTERMENT <i>St. John's Church</i></p>		<p>CITY OF INTERMENT <i>Baltimore</i></p>	
<p>STATE OF INTERMENT <i>Maryland</i></p>		<p>COUNTY OF INTERMENT <i>Harford</i></p>	
<p>DATE OF BURIAL <i>Jan 17 1923</i></p>		<p>TIME OF BURIAL <i>11:00 AM</i></p>	
<p>PLACE OF BURIAL <i>St. John's Church</i></p>		<p>CITY OF BURIAL <i>Baltimore</i></p>	
<p>STATE OF BURIAL <i>Maryland</i></p>		<p>COUNTY OF BURIAL <i>Harford</i></p>	

Page 4 of 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11366

11394 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		j. STREET ADDRESS 38 Rockwell	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arnold Middle Deel Last		4. DATE OF DEATH Month Oct. Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 28, 1906
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bulldozer Operator		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Noah Deelb		14. MOTHER'S MAIDEN NAME Mary Presley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 235-01-8637	
17. INFORMANT Mrs. Anna R. Deel, Edgewood, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. fs. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/12/58 , 19____, to 10/12/58 , 19____, that I last saw the deceased alive on 4:40 PM , 19____, and that death occurred at 4:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Louis Kahan		DATE SIGNED Box 966 Edgewood, MD	
PHYSICIAN'S NAME (Type) E. Louis Kahan MD		Box 966 Edgewood, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/1958	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McConno Jr		ADDRESS Abingdon, Md.,	
24a. REC'D BY REGISTRAR DATE OCT 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Harford 11368
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
c. LENGTH OF STAY IN 1b 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bush Chapel Road | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen
d. STREET ADDRESS 1136 Baltimore St
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William Lee Dorsey
First Middle Last
4. DATE OF DEATH October 26 1958
Month Day Year | | 5. SEX M 6. COLOR OR RACE C 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Oct. 25, 1881 9. AGE (In years last birthday) 77 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Custodian | | 10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Proving Ground | |
| 11. BIRTHPLACE (State or foreign country) Darlington, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Matilda Dorsey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-22-0923 | |
| 17. INFORMANT Mrs. Laura L. Dorsey - Aberdeen, Md. | | Address 436 Baltimore St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Herald C Palmer | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Gerold C Palmer | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-30-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Greenspring Cemetery | | 22d. LOCATION (City, town, or county) (State) Greenspring - Harford Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Bullock, Harford Co., Md. | | 24a. REC'D BY REGISTRAR Arthur J. Bullock 24b. REGISTRAR'S SIGNATURE 10-26-58 | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11395 CERTIFICATE OF DEATH

11368

Reg. Dist. No.

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|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen | | | | c. LENGTH OF STAY IN 1b
2 weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MD | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First IMELDA Middle FARRELLY Last FARRELLY | | | | 4. DATE OF DEATH Month October Day 1 Year 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1 Oct 58 | |
| 9. AGE (In years last birthday) yrs. 25 | | IF UNDER 1 YEAR Months 2 Days 25 | | IF UNDER 24 HRS. Hours 2 Min. 25 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME John Michael Farrelly | | | | 14. MOTHER'S MAIDEN NAME Rosanna Kathleen Byrne | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) N/A | | | | 16. SOCIAL SECURITY NO. N/A | | | |
| 17. INFORMANT (Father) John M Farrelly | | | | Address C-2-2 Grant Ave Aberdeen, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776X
DUE TO (c) at birth
INTERVAL BETWEEN ONSET AND DEATH at birth | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 8:30 PM 1 Oct 58 to 10:55 PM 1 Oct 1958 , that I last saw the deceased alive on 10:00 PM 1 Oct 1958 , and that death occurred at 10:55 M , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John Z Delf M.D. | | | | DATE SIGNED 1 Oct 58 | | | |
| PHYSICIAN'S NAME (Type) JOHN Z DELP CAPT MC | | | | ADDRESS USAH APG Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 10/6/58 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Rock E. P. H. | | | | 22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarum ADDRESS Aberdeen Md | | | | 24a. REC'D BY REGISTRAR OCT 6 '58 DATE | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kneal | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11358

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

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11369

CERTIFICATE OF DEATH

11369

Reg. Dist. No.

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|---|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Havre de Grace | | | | c. LENGTH OF STAY IN 1b
24 Havre de Grace | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
650 Otsego Street | | | | d. STREET ADDRESS
650 Otsego Street | | | |
| 3. NAME OF DECEASED
(Type or print) COLUMBUS FRANK FLETCHER | | | | 4. DATE OF DEATH
Month October Day 11 Year 19 58 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
29 March 1893 | | 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Freight Conductor | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA. | | | | 13. FATHER'S NAME
COLUMBUS P. FLETCHER | | | |
| 14. MOTHER'S MAIDEN NAME
JULIA K. TROUTWINE | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO.
717 07 5944 | | | | 17. INFORMANT
Ruth Fletcher Address 650 Otsego St. Havre de Grace, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
ONE HOUR
SIX MONTHS
YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from JANUARY, 1958 , to OCTOBER, 1958 , that I last saw the deceased alive on 10/11, 1958 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Irwin Randall Ross M.D. | | | | ADDRESS (Street, city or town, state) 200 N. Union Ave. DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) Irwin Randall Ross M.D. | | | | Havre de Grace, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/13/58 | | 22c. NAME OF CEMETERY OR CREMATORY
Grove Presbyterian | | 22d. LOCATION (City, town, or county) (State)
Aberdeen, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Harving ADDRESS Aberdeen, Md. | | | | 24a. REC'D BY REGISTRAR
OCT 15 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11370

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

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|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> 11396
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>
c. LENGTH OF STAY IN lb <u>POA</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Harford</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>314 Aberdeen</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Victoria ANN Gaudette</u>
First <u>Victoria</u> Middle <u>ANN</u> Last <u>Gaudette</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>11</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Aug 26 1958</u> | | 9. AGE (In years last birthday) yrs. <u>1</u> 10. IF UNDER 1 YEAR Months <u>16</u> 11. IF UNDER 24 HRS. Hours <u>16</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> | |
| 10c. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Stanley C. Vogel</u> | | 14. MOTHER'S MAIDEN NAME <u>Gail M. Gaudette</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>** **</u> | | 16. SOCIAL SECURITY NO. <u>** **</u> | |
| 17. INFORMANT <u>Gail M. Gaudette</u> | | Address <u>D-11-2, Grant Aberdeen, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gastro enteritis</u>
<u>571.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u></u>
(c) <u></u>
[a], stating the underlying cause lost. (c) <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Lewell C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, Md</u> DATE SIGNED <u>10-11-58</u> | | EXAMINER'S NAME (Type) <u>Gerold C Palmer M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/13/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u> | | 22d. LOCATION (City, town, or county) (State) <u>Abingdon, Md Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Garring</u> ADDRESS <u>Aberdeen, Md.</u> | | 24a. REC'D BY REGISTRAR <u>OCT 15 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please, execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050191XV5

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HUMAN BODY

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13500

MISSOURI STATE DEPARTMENT OF HEALTH - JEFFERSON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13500

Form with various fields for medical examination, including sections for cause of death, manner of death, and examiner's signature. The form is partially filled out with handwritten text.

10/15/50
Jefferson, Mo.
13500

11397 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
(Rural) Aberdeen | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
(Rural) Aberdeen | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
RD. #3, Box 298 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First IDA Middle MAE Last GREEN | | 4. DATE OF DEATH
Month October Day 4 Year 19 58 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/30/1897 |
| 9. AGE (In years last birthday)
61 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Louis Ridgley | | 14. MOTHER'S MAIDEN NAME
Virgil Gibson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
_____ | |
| 17. INFORMANT
Charles H. Green | | Address Rt. 3, Box 298
Aberdeen, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
Myocardial Infarction
(c)
Coronary Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH
10 yr |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized Arteriosclerosis | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. _____
p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from _____, 19 45 , to 10-4-1958 that I last saw the deceased alive on 10-4-1958 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED _____ | | | |
| ACTUAL SIGNATURE Peter P. Rodman M.D. | | DATE SIGNED 8 Law Street | |
| PHYSICIAN'S NAME (Type) Peter P. Rodman M.D. | | ADDRESS Aberdeen, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10/7/58 | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cemetery | 22d. LOCATION (City, town, or county) (State)
R.D. Aberdeen, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John P. Farrelly | | ADDRESS
Aberdeen, Md. | 24a. REC'D BY REGISTRAR
OCT 9 '58 |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11370 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Beltair</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upper Cross Roads</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>County Home</u> | | | | d. STREET ADDRESS
<u>Fallston Rd</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>James Ellis Greene</u> | | | | 4. DATE OF DEATH Month Day Year
<u>Oct - 13, 1958</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 1, 1881</u> | 9. AGE (In years last birthday)
<u>77</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Boone NC</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Saul Greene</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Gregg</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>- 740 -</u> | | 17. INFORMANT Address
<u>Roscoe Greene Fountain Green Harford Co</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema Congestive heart failure</u>
<u>422.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Cardio-Vascular disease, decompensated</u>
DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 1, 1950</u> , 19 <u>58</u> to <u>Oct 13, 1958</u> that I last saw the deceased alive on <u>Oct 13, 1958</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>Forest Hill Md 10/14/58</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Oct 15-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Upper Cross Rds Baptist</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Upper X Roads Harford Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Martin E. Kutz Jarrettville Md</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 17 '58</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Christina S. Thomas</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11398 CERTIFICATE OF DEATH

11373

Reg. Dist. No.

| | | | |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Md. Rural</u> | | c. LENGTH OF STAY IN 1b <u>4 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>CHESTER</u> Middle <u>EARL</u> Last <u>HAGAN</u> | | 4. DATE OF DEATH
Month <u>OCTOBER</u> Day <u>27</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1894 Aug 29 64</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Georgetown Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Hagan</u> | | 14. MOTHER'S M maiden name <u>Lilly Duff</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>21301-2415</u> | |
| 17. INFORMANT <u>James E. Hagan</u> Address <u>Bel Air Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4221 CONGESTIVE HEART FAILURE</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR Disease</u>
DUE TO
(c) <u>5 years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Good general health and malnutrition</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>JANUARY - 1958</u> , to <u>October 27, 1958</u> , that I last saw the deceased alive on <u>October 18, 1958</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Paul S. Stonesifer Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>115 E. Ford Ave.</u> DATE SIGNED <u>10/27/58</u> | |
| PHYSICIAN'S NAME (Type) <u>PAUL S. STONESIFER JR.</u> | | <u>BEL AIR, MD.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct 30/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Pa.</u> | 22d. LOCATION (City, town, or county) (State) <u>Pleasant Grove Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u> ADDRESS <u>Rising Sun Md.</u> | | 24a. REC'D BY REGISTRAR <u>OCT 30 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11371 CERTIFICATE OF DEATH

11374

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
o. STATE <u>md.</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> | | | | c. LENGTH OF STAY IN 1b <u>10 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Cleveland</u> Last <u>Hall</u> | | | | 4. DATE OF DEATH <u>Oct. 17, 1958</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>md 6/2/1884</u> yrs. <u>74</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House Carpenter</u> | | 11. BIRTHPLACE (State or foreign country) <u>md., Leonardtown,</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>James Hall</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Latham</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>212-14-3455</u> | | 17. INFORMANT <u>Charles F. Hall - son</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>293X Atherosclerotic Cerebrovascular + Cardiovascular Disease</u>
DUE TO (b) <u>Cerebrovascular Accident</u>
DUE TO (c) <u>Congenital Heart Failure 2nd to Nutritional Anemia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/18</u> , 19 <u>58</u> , to <u>10/17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/16</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A</u> . M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. Louis Kahan</u> | | | | ADDRESS (Street, city or town, state) <u>Box 966 Edgewood, Maryland</u> DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>E. Louis Kahan MD</u> | | | | ADDRESS <u>Box 966 Edgewood, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 20, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's</u> | | 22d. LOCATION (City, town, county, state) <u>Balto., Maryland.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. Thomas Jr</u> ADDRESS <u>Abingdon, Maryland.</u> | | | | 24a. REC'D BY REGISTRAR <u>OCT 22 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Baltimore, Maryland.

Oct. 10, 1958

St. Stephen's

Baltimore, Maryland.

Burial

6/2/58

House Carpenter

Baltimore, Maryland.

ST-14-3452

no

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11399 CERTIFICATE OF DEATH

11375

Reg. Dist. No.

| | | | |
|--|---------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Forest Hill</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Forest Hill</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>1</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Henrietta</u> First <u>Jenkins</u> Middle Last | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>26</u> Year <u>1958</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 22-1904</u> 54 yrs. |
| 9. AGE (In years last birthday) | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>at home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Putnam Road, Harford</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Henry E. Turner</u> | | 14. MOTHER'S MAIDEN NAME
<u>Annie M. Hall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>-</u> | |
| 17. INFORMANT
<u>Briley Jenkins Forest Hill Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, terminating</u>
<u>592x</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cronic Nephritis with hypertension</u>
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>260x Diabetes Mellitus (mild)</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>50 min.</u>
<u>4 yrs.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. 11. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1952</u> , 19____, to <u>Oct. 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 23</u> , 19 <u>58</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. | | ADDRESS (Street, city or town, state) <u>Forest Hill Md.</u> | |
| DATE SIGNED <u>10-26-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Willard P. Hudson</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Oct 29 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Fairview Col. Forest Hill Harford - Md.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Martin Skutz Janethold Md.</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR
DATE <u>OCT 31 '58</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kline</u> | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11372

CERTIFICATE OF DEATH

11376

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------|--|-------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Harford</i> | | MARYLAND | | STATE <i>md</i> | | COUNTY <i>Harford</i> | |
| CITY OR TOWN <i>Bel Air Md</i> | | LENGTH OF STAY (in this place) <i>Life</i> | | CITY OR TOWN <i>Bel Air</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (if rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <i>Blanche</i> (Middle) <i>Ruff</i> (Last) <i>Johnson</i> | | | | (Month) <i>Oct</i> (Day) <i>23</i> (Year) <i>1958</i> | | | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>bl</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i> | 8. DATE OF BIRTH <i>Dec 16-1888</i> | 9. AGE last birthday <i>69</i> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home duties</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Bel Air Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>US</i> | |
| 13. FATHER'S NAME <i>Richard A Ruff</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Morton</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | | 17. INFORMANT & ADDRESS <i>Miss Elizabeth J. Whittington Bel Air RD(1) Box 411</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 199.2 IMMEDIATE CAUSE (A) <i>CARDIO-RESPIRATORY FAILURE</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 WEEKS</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>METASTATIC CA</i> | | | | | | <i>10 MO</i> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>ORIGINAL SITE ABDOMINAL</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>13 OCT</i> , 19 <i>58</i> , to <i>DATE</i> , 19....., that I last saw the deceased alive on <i>13 OCT</i> , 19 <i>58</i> , and that death occurred at <i>10P</i> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>H. P. Andrew</i> | | | | DATE SIGNED <i>24 OCT '58</i> | | | |
| M.D. <i>401 Franklin St. Baltimore, Md</i> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>Oct 27-1958</i> | | NAME OF CEMETERY OR CREMATORY <i>Hendon's Hill</i> | | LOCATION (City, town, or county) (State) <i>Bel Air Rural Md</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <i>OCT 28 '58</i> | | | | | | | |

Item 8, Film G234, 10/9/58, pay

11373

CERTIFICATE OF DEATH

Reg. Dist. No. 11377

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Hartford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision)
o. STATE <u>md</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u> | | d. STREET ADDRESS <u>Broad ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>B.</u> Last <u>Johnson</u> | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1889</u>
<u>7-12-1958</u> |
| 9. AGE (In years and birthday) yrs. <u>69</u> | | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph B. Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Bryson</u> | |
| 15. WAS DECEASED IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>717-07-6059</u> | |
| 17. INFORMANT <u>Paul Johnson</u> | | Address <u>Perryville, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO (c) <u>sudden</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>19</u>
p. m. <u></u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Jan 18</u> , 19 <u>57</u> , to <u>Oct 5th</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Oct 5th</u> , 19 <u>58</u> and that death occurred at <u>9:45 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D. | | ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>Oct 5th 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> | | <u>Harre-de-Grace, Md.</u> at <u>10 P.M.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-8-1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>North East, M.E.</u> | 22d. LOCATION (City, town, or county) (State) <u>North East, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leea Patterson</u> | | ADDRESS <u>Perryville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>ACT</u> | | 24b. REGISTRAR'S SIGNATURE <u>7 '58</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11374 CERTIFICATE OF DEATH

Reg. Dist. No. 11378

| | | | |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> | | c. LENGTH OF STAY IN 1b <u>9 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAURE de Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u> 07X-2 ✓
d. STREET ADDRESS | |
| 3. NAME OF DECEASED
(Type or print) First <u>Samuel</u> Middle <u>Keim</u> Last <u>Keim</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/31/80</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Somerset County, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jacob Keim</u> | | 14. MOTHER'S MAIDEN NAME <u>Isabelle Geiger</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no.</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Peter E. Wright</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>6 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>52</u> to <u>10/16</u> , 19 <u>58</u> that I last saw the deceased alive on <u>October 16</u> , 19 <u>58</u> , and that death occurred at <u>1:03 A.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>10/16/58</u>
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u> <u>Rising Sun, Md.</u> | | | |
| 22b. BUREAU, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 18, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Pk.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Nr. Elkton, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u> ADDRESS <u>Donald M. The Donald M. Pippin</u> | | 24a. REC'D BY REGISTRAR <u>21 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------|--|-------------|--|------------------|--|-------------------|--|------------------|--|--------------------------|--|----------------------------|--|--------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Race | | 4. Date of birth | | 5. Place of birth | | 6. Date of death | | 7. Place of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | | 11. Signature of registrar | | 12. Date of registration | |
| John Doe | | Male | | White | | 1900 | | New York | | 1950 | | New York | | Heart Disease | | Natural | | [Signature] | | [Signature] | | 1950 | |
| 13. Name of informant | | 14. Relationship | | 15. Address | | 16. City | | 17. State | | 18. Country | | 19. Date of registration | | 20. Signature of registrar | | 21. Date of registration | | 22. Signature of registrar | | 23. Date of registration | | 24. Signature of registrar | |
| Jane Doe | | Wife | | 123 Main St | | New York | | New York | | USA | | 1950 | | [Signature] | | 1950 | | [Signature] | | 1950 | | [Signature] | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11375

CERTIFICATE OF DEATH

Reg. Dist. No.

11379

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u> | | d. STREET ADDRESS <u>RT 1</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Susan Elizabeth Kell</u> | | 4. DATE OF DEATH Month Day Year <u>October 9 1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-25-1883</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. <u>10 9</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>James H. Kilmore</u> | | 14. MOTHER'S MARDEN NAME <u>Sarah L. Lewis</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT Address <u>R. F. D. #1</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart disease</u>
DUE TO (c) <u>Advanced age</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10/1/58</u> , 19 <u>58</u> , to <u>10/9/58</u> , 19 <u>58</u> that I last saw the deceased alive on <u>October 9</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Wm. H. Woodman M.D.</u> | | ADDRESS (Street, city or town, state) <u>407 S. Princeton Ave</u> DATE SIGNED <u>10/9/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Otelis J. Bullock</u> | | 22a. LOCATION (City, town, or county) (State) <u>Aberdeen, Harford Co. Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-12-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Harford Co. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelis J. Bullock, Harve de Grace, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

55611

1

7

11400

11400

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11380

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Aberdeen Proving Ground</u> | | c. LENGTH OF STAY IN 1b
<u>8 Hours</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>US Army Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>GAITHER</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>13</u> Year <u>19 58</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb 26, 1916</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Alvin H. Chrisp</u> | | 14. MOTHER'S MAIDEN NAME
<u>Flossey W. Creekmoore</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>231-01-0980</u> | |
| 17. INFORMANT
<u>John Keller</u> | | Address
<u>Long Bar Harbor, Abingdon, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitis</u>
DUE TO
(c) <u>Chronic Pancreatitis</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 Hour</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>October 12</u> , 19 <u>58</u> , to <u>October 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 13</u> , 19 <u>58</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>US Army Hosp, Aberdeen Proving Gnd., Md</u> <u>Oct 13, 1958</u> | | | |
| ACTUAL SIGNATURE
<u>Jerome B. Bryant Jr.</u> | | PHYSICIAN'S NAME (Type)
<u>JEROME B. BRYANT Jr. Capt. MC</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>10/16/58</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John G. Tarring</u> | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 15 '58</u> | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Klaus</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

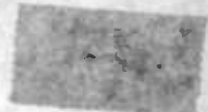
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1100



FORM 100-1

| | | | | | | | | | |
|-----------------------------------|--|-----------------------------------|--|---------------------------------|--|----------------------------------|--|-------------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | | <p>5. PLACE OF BIRTH</p> | |
| <p>6. OCCUPATION</p> | | <p>7. CAUSE OF DEATH</p> | | <p>8. MANNER OF DEATH</p> | | <p>9. PLACE OF DEATH</p> | | <p>10. TIME OF DEATH</p> | |
| <p>11. SIGNATURE OF PHYSICIAN</p> | | <p>12. SIGNATURE OF REGISTRAR</p> | | <p>13. SIGNATURE OF WITNESS</p> | | <p>14. SIGNATURE OF DECEASED</p> | | <p>15. SIGNATURE OF NEXT OF KIN</p> | |
| <p>16. SIGNATURE OF CLERK</p> | | <p>17. SIGNATURE OF JUDGE</p> | | <p>18. SIGNATURE OF SHERIFF</p> | | <p>19. SIGNATURE OF CORONER</p> | | <p>20. SIGNATURE OF JURY</p> | |

Maryland State Department of Health

Baltimore, Maryland

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11376

CERTIFICATE OF DEATH

11381

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD DE GRACE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - BEL AIR | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP. | | | | d. STREET ADDRESS Box 188 | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last IVORY PEARL KENNEDY | | | | 4. DATE OF DEATH Month Day Year OCTOBER 24 1958 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8 May 1883 | |
| 9. AGE (In years lost birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME THOMAS BUCKINGTON GRAFTON | | | | 14. MOTHER'S MAIDEN NAME MARY MINNICK | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address T.B. Grafton, Box 192, Bel Air, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cerebral Vascular Disease
(c) Chronic Cardiovascular disease with hypertension | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Ascending thrombosis of popliteal artery | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from OCT 17 , 1958, to OCT 24 , 1958, that I last saw the deceased alive on OCT 23 , 1958, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Willard P. Hudson | | | | ADDRESS (Street, city or town, state) Forest Hill, Md | | DATE SIGNED 10/24/58 | |
| PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/26/58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery | | 22d. LOCATION (City, town, or county) (State) R.D. Bel Air Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John G. Tarring Aberdeen, Md. | | | | 24a. REC'D BY REGISTRAR DATE OCT 27 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11377

CERTIFICATE OF DEATH

11382

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|--|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Md. b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 31 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial | | | | e. STREET ADDRESS 720 Webb St. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bradley Steven La Buwi | | | | 4. DATE OF DEATH Month Day Year October 5 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 3, 1958 | 9. AGE (In years last birthday) yrs. 1 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 1 18 3 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Lewis Royal La Buwi | | | | 14. MOTHER'S MAIDEN NAME Jean Carol Hankau | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Lewis R. La Buwi | | Address 720 Webb St. Aberdeen, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY ATELECTASIS
762.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTRA UTERINE ANOXIA
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 36 hrs
4 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 3 , 19 58 , to Oct 5 , 19 58 , that I last saw the deceased alive on October 5 , 19 58 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE B.J. Plunkett Jr. | | | | ADDRESS (Street, city or town, state) 617 W. Bel Air Ave. | | DATE SIGNED 10-6-58 | |
| PHYSICIAN'S NAME (Type) B.J. Plunkett Jr. M.D. | | | | Aberdeen, Md. | | 10-6-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-9-58 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring | | | | ADDRESS Aberdeen, Md. | | 24a. REC'D BY REGISTRAR DAT OCT 9 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE John G. Tarring | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071262XV4

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT

11378

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Hanford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md</i> b. COUNTY <i>Cecil</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanford Grace</i> | | c. LENGTH OF STAY IN 1b <i>3 hours</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hanford Memorial Hospital</i> | | d. STREET ADDRESS <i>US Route 40</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Francis Le Blanc</i> | | 4. DATE OF DEATH <i>October 18 1958</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3/29/1923</i> |
| 9. AGE (In years last birthday) <i>35 yrs.</i> | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Air Force</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Kilgus Marie</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Edward Le Blanc</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Dietz</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | |
| 17. INFORMANT <i>O'Donnell Funeral Home</i> | | Address <i>96 Main St. Havre, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Fracture Skull</i>
812X DUE TO
Conditions, if any, which gave rise to immediate cause (b) <i>812X</i>
(a), stating the underlying cause lost. DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident auto pedestrian type</i> | |
| 20c. TIME OF INJURY Month, Day, Year <i>10-18-58</i> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>US Route 40</i> | 20f. (City or town) (County) (State) <i>Northeast Cecil Md.</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Gerald C Palmer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>10-18-58</i> | |
| EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>10/22/58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Hollycross</i> | 22d. LOCATION (City, town, or county) (State) <i>Havre, Cecil Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Funerary Co. Harold Grace, Md.</i> | | 24a. REC'D BY REGISTRAR <i>Oct 21 '58</i> | 24b. REGISTRAR'S SIGNATURE <i>Clifton E. Kline</i> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
HEALTH DEPT.

1930

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11383

THIS IS TO CERTIFY

DATE OF DEATH
(month, day, year)

DECEASED

PLACE OF DEATH

RESIDENCE

PLACE OF BIRTH

EDUCATION

DATE OF BIRTH

SEX

PLACE OF DEATH

EDUCATION

DATE OF BIRTH

SEX

PLACE OF DEATH

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EDUCATION

DATE OF BIRTH

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11379

CERTIFICATE OF DEATH

11384

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HAYRE DE GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HAYRE DE GRACE</u> 24 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>221 So. WASHINGTON ST</u> | | d. STREET ADDRESS
<u>221 So. WASHINGTON ST</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>WILLIAM</u> Middle <u>BENJAMIN</u> Last <u>MAULDIN</u> | | 4. DATE OF DEATH
Month <u>OCT.</u> Day <u>14</u> Year <u>1958</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JUNE 11, 1882</u> |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>FISHERMAN-WATCHMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RETIRED</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>EDWARD WILMER MAULDIN</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY ELLA CURRIER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>215-12-2900</u> | |
| 17. INFORMANT
<u>EDWARD W. MAULDIN</u> | | Address
<u>HAYRE DE GRACE MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatous</u>
<u>199.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostate - Colon -</u>
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-27</u> , 19 <u>58</u> , to <u>10-14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>58</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>C. L. Lewis</u> M.D. | | ADDRESS (Street, city or town, state)
<u>HAYRE DE GRACE MD</u> | |
| DATE SIGNED
<u>10/14/58</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>C. L. Lewis</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>OCT. 16, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>ANGEL HILL</u> | | 22d. LOCATION (City, town, or county) (State)
<u>HAYRE DE GRACE, MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>R. Madison Mitchell</u> | | ADDRESS
<u>HAYRE DE GRACE MD</u> | |
| 24a. REC'D BY REGISTRAR
<u>OCT 20 '58</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. House</u> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11401

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>md</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Darlington</i> | | c. LENGTH OF STAY IN 1b
<i>10 minutes</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Office Dr FPS Woodgess</i> | | e. STREET ADDRESS
<i>Darlington Md</i> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Curtis E</i> Middle <i>MacAllister</i> Last | | DATE OF DEATH
Month <i>October</i> Day <i>13</i> Year <i>1958</i> | |
| 5. SEX
<i>M</i> | 6. COLOR OR RACE
<i>W</i> | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH
<i>March 20, 1905</i> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done, or retired)
<i>Club School Board Baltimore</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Baltimore</i> | 11. BIRTHPLACE (State or foreign country)
<i>Harford Co Md, SA</i> |
| 13. FATHER'S NAME
<i>John McCallister</i> | | 14. MOTHER'S MAIDEN NAME
<i>Emma Riley</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<i>World War II</i> | | 16. SOCIAL SECURITY NO.
<i>213-12-6580</i> | |
| 17. INFORMANT
<i>Mrs. Francis Moor</i> | | Address
<i>Street Harford Co Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic C.V. disease</i>
<i>422.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>002X</i> (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary tb, far advanced, inactive & Emphysema</i> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<i>Gerald C Palmer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bela A. M</i> DATE SIGNED <i>10-13-58</i> | |
| EXAMINER'S NAME (Type)
<i>Gerald E. Palmer MD</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
<i>Oct. 16, 1958</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Baltimore National Cem</i> | 22d. LOCATION (City, town, or county) (State)
<i>Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>H S Bailey</i> | | 24. REC'D BY REGISTRAR
<i>Arthur S. Kraus</i> | |
| 25. REGISTRAR'S SIGNATURE | | 26. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11380 CERTIFICATE OF DEATH

Reg. Dist. No. 11386

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITEFORD</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WHITEFORD</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 HARFORD MEMORIAL Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>CLYDE</u> Middle <u>MORRIS</u> Last <u>MORRIS</u> | | | | 4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>25</u> Year <u>1958</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov. 9, 1912</u> | |
| 9. AGE (In years last birthday) <u>45</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u> | | 11. BIRTHPLACE (State or foreign country) <u>WHITEFORD, MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>JOHN CARROLL MORRIS</u> | | 14. MOTHER'S MAIDEN NAME <u>EDITH GERTRUDE BOYLE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>MRS. LOUISE MORRIS, WHITEFORD, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
<u>331X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 <u>58</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 21. I certify that I attended the deceased from <u>10/25</u> , 19 <u>58</u> , to <u>10/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>58</u> , and that death occurred at <u>12:55 A.M.</u> from the causes and on the date stated above. | | | |
| 21. I certify that I attended the deceased from <u>10/25</u> , 19 <u>58</u> , to <u>10/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>58</u> , and that death occurred at <u>12:55 A.M.</u> from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) <u>Harlington Md</u> DATE SIGNED <u>10/25/58</u> | | | |
| ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>DUDLEY PHILLIPS</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10-28-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>TABERNACLE</u> | | 22d. LOCATION (City, town, or county) (State) <u>WHITEFORD, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haskins, Delta, Pa.</u> ADDRESS _____ | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 29 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11381

CERTIFICATE OF DEATH

11387

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Hanford</i> <i>Maryland</i> <i>MARYLAND</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. COUNTY <i>Hanford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanford</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanford</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Franklin</i> Middle <i>Price</i> Last <i>PRICE</i> | | 4. DATE OF DEATH <i>10/8/58</i> Month <i>10</i> Day <i>8</i> Year <i>19</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1/3/1873</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i> | 9. AGE (In years last birthday) <i>85</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <i>Hanford Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>James Price</i> | | 14. MOTHER'S MAIDEN NAME <i>Ella Dorrell</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | |
| 17. INFORMANT <i>Josephine P. Price</i> Address <i>514 Carbon, Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
<i>420.0</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i>
(c) <i>Generalized arteriosclerosis</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>July</i> , 1954, to <i>Oct.</i> , 1958, that I lost saw the deceased alive on <i>6/1/58</i> , 1958, and that death occurred at <i>M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>John H. Woodman</i> M.D. | | ADDRESS (Street, city or town, state) <i>407 S. Union Ave. Hanford Md.</i> DATE SIGNED <i>10/8/58</i> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <i>10/14/58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i> | 22d. LOCATION (City, town, or county) (State) <i>Hanford Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Woodman</i> ADDRESS <i>Hanford Md.</i> | | 24a. REC'D BY REGISTRAR DATE <i>OCT 17 '58</i> | 24b. REGISTRAR'S SIGNATURE <i>Colbert S. Kneib</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, illegible text and markings are visible throughout the form, likely bleed-through from the reverse side. The form includes fields for patient information, cause of death, and medical history.]

1 ~~A~~

11382 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11382

CERTIFICATE OF DEATH

11388

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen | | c. LENGTH OF STAY IN 1b
31 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
33 N. Phila. Blvd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HILDA Middle H. Last RADCLIFFE | | 4. DATE OF DEATH
Month October Day 11 Year 1958 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4 December 1907 |
| 9. AGE (In years last birthday) yrs. 50 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 11. BIRTHPLACE (State or foreign country)
INDIANA Indiana | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Harvey Holden | | 14. MOTHER'S MAIDEN NAME
Wava Mingis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
214 24 3532 | |
| 17. INFORMANT
George S. Radcliffe | | Address 33 N. Phila Blvd. Aberdeen, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema, C.V.A.
163X DUE TO Cancer of Lungs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
12 Mon G |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from JAN 1, 1958 to Oct 10, 1958 , that I last saw the deceased alive on Oct 10, 1958 , and that death occurred at M , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Andre Weiss | | ADDRESS (Street, city or town, state) 17 N. Phila Blvd. DATE SIGNED | |
| PHYSICIAN'S NAME (Type) Andre Weiss M.D. | | Aberdeen, Md. 10/13/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10/14/58 | 22c. NAME OF CEMETERY OR CREMATORY
Hametown Cemetery | 22d. LOCATION (City, town, or county) (State)
Shrewsberry, Penna. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring | | 24a. REC'D BY REGISTRAR
Oct 15 '58 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Knaus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

DATE OF DEATH

REPORTED BY

DATE OF REPORT

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

11383 CERTIFICATE OF DEATH

11389

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAURE DE COPE | | c. LENGTH OF STAY IN 1b
16 HRS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X STREET | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
HARFORD MEMORIAL Hosp. | | | | d. STREET ADDRESS
1 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
CHRISTOPHER A RICE | | | | 4. DATE OF DEATH Month Day Year
OCTOBER 14 19 58 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
OCTOBER 13, 1958 | |
| 9. AGE (In years lost birthday) yrs.
16 | | 10. IF UNDER 1 YEAR: Months Days Hours Min.
16 15 | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NEWBORN | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
HOWARD WEBSTER | | | | 14. MOTHER'S MAIDEN NAME
ARLENE VIRGINIA RICE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mrs Edith Rice Street, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary atelectasis
762.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intrauterine anoxia
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 13, 1958 , to Oct. 14, 1958 , that I last saw the deceased alive on Oct. 14, 1958 , and that death occurred at 5:45 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Arline S. Marshall M.D. | | | | ADDRESS (Street, city or town, state) Harford Mem. Hosp. Haure de Cope DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-16-58 | | 22c. NAME OF CEMETERY OR CREMATORY
Rock's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Rock's Harford Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Elmer E Bullock | | | | ADDRESS
Harford Mem. Hosp. | | 24a. REC'D BY REGISTRAR
OCT 20 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Knaus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071211XV4

11383 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11383

DATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED
CHRISTOPHER | | 2. SEX
M | | 3. AGE
35 | |
| 4. OCCUPATION
SALES | | 5. PLACE OF BIRTH
MD | | 6. DATE OF BIRTH
1910 | |
| 7. PLACE OF DEATH
MD | | 8. CAUSE OF DEATH
HEART DISEASE | | 9. MANNER OF DEATH
NATURAL | |
| 10. SIGNATURE OF DECEASED
CHRISTOPHER | | 11. SIGNATURE OF WITNESS
CHRISTOPHER | | 12. SIGNATURE OF PHYSICIAN
CHRISTOPHER | |
| 13. SIGNATURE OF CORONER
CHRISTOPHER | | 14. SIGNATURE OF JURY
CHRISTOPHER | | 15. SIGNATURE OF JUDGE
CHRISTOPHER | |
| 16. SIGNATURE OF CLERK
CHRISTOPHER | | 17. SIGNATURE OF REGISTRAR
CHRISTOPHER | | 18. SIGNATURE OF ARCHIVIST
CHRISTOPHER | |
| 19. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 20. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 21. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 22. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 23. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 24. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 25. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 26. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 27. SIGNATURE OF ASSISTANT ARCHIVIST
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| 28. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 29. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 30. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 31. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 32. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 33. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 34. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 35. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 36. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 37. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 38. SIGNATURE OF ASSISTANT REGISTRAR
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| 40. SIGNATURE OF ASSISTANT CLERK
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| 43. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 44. SIGNATURE OF ASSISTANT REGISTRAR
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CHRISTOPHER | |
| 46. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 47. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 48. SIGNATURE OF ASSISTANT ARCHIVIST
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| 49. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 50. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 51. SIGNATURE OF ASSISTANT ARCHIVIST
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| 52. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 53. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 54. SIGNATURE OF ASSISTANT ARCHIVIST
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| 55. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 56. SIGNATURE OF ASSISTANT REGISTRAR
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CHRISTOPHER | |
| 58. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 59. SIGNATURE OF ASSISTANT REGISTRAR
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| 61. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 62. SIGNATURE OF ASSISTANT REGISTRAR
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CHRISTOPHER | |
| 64. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 65. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 66. SIGNATURE OF ASSISTANT ARCHIVIST
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| 67. SIGNATURE OF ASSISTANT CLERK
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| 70. SIGNATURE OF ASSISTANT CLERK
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| 73. SIGNATURE OF ASSISTANT CLERK
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| 76. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 77. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 78. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 79. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 80. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 81. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 82. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 83. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 84. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 85. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 86. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 87. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 88. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 89. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 90. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 91. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 92. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 93. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 94. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 95. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 96. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 97. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 98. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 99. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |
| 100. SIGNATURE OF ASSISTANT CLERK
CHRISTOPHER | | 101. SIGNATURE OF ASSISTANT REGISTRAR
CHRISTOPHER | | 102. SIGNATURE OF ASSISTANT ARCHIVIST
CHRISTOPHER | |

RECEIVED

11383

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11390

Reg. Dist. No.

FOR STATE HEALTH DEPT.

| | | | |
|---|---------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> | | c. LENGTH OF STAY IN 1b <u>18 Months</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>James Edward Roark</u> | | 4. DATE OF DEATH <u>October 2 19 58</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 11, 1903</u> |
| 9. AGE (In years last birthday) <u>55</u> yrs. | | 10. IF UNDER 1 YEAR <u>2</u> Months <u>19</u> Days <u>58</u> Hours <u>58</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborn</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>John Roark</u> | | 14. MOTHER'S MAIDEN NAME <u>Bethine Roark</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>240-20-3839</u> | |
| 17. INFORMANT <u>Worth Roark Nottingham Rt 1</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>2 SW L chest</u>
<u>976X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u>
DUE TO (c) <u></u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>7</u> Hour <u>a. m.</u> <u>10-2</u> 19 <u>58</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Forest Hill Harford Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, Md.</u> DATE SIGNED <u>10-2-58</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>Oct 6/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Roark</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> | | 24a. REC'D BY REGISTRAR <u>Bel Air Md</u> DATE <u>6 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

LAST CERTIFICATE
NUMBER
DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

DECEASED
NAME
AGE
SEX
RACE
RELATIONSHIP TO DECEASED
OCCUPATION

DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

CAUSE OF DEATH
MANNER OF DEATH
DISEASE OR INJURY
IMMEDIATE CAUSE
INTERMEDIATE CAUSE
UNDERLYING CAUSE

TO BE FILLED BY THE EXAMINER
DATE OF EXAMINATION
PLACE OF EXAMINATION
CITY
COUNTY
STATE

SIGNATURE OF EXAMINER
DATE OF SIGNATURE
PLACE OF SIGNATURE
CITY
COUNTY
STATE

NOTARY PUBLIC
DATE OF NOTARIZATION
PLACE OF NOTARIZATION
CITY
COUNTY
STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11403

CERTIFICATE OF DEATH

11391

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Run</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Run</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>Harre de Grace Star Route</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Herman Nichols Schweers</u> | | | | 4. DATE OF DEATH <u>10/11/58</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1/22/1888</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Business</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | | 11. BIRTHPLACE (State or foreign country) <u>Lancaster Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>August A. Schweers</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Minnie Neiman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT <u>Kathryn B. Schweers</u> Address <u>Rock Run Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>
DUE TO <u>420.1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u>
DUE TO <u>Hypertensive arteriosclerosis</u>
(c) <u>Intermittent claudication</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr</u>
<u>1 day</u>
<u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 11, 1958</u> , to <u>Oct 11, 1958</u> , that I last saw the deceased alive on <u>Oct 11, 1958</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. Randall Ross</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>200 N. UNION AVE</u> | | DATE SIGNED <u>10/15/58</u> | |
| PHYSICIAN'S NAME (Type) <u>I. RANDALL ROSS</u> | | | | HAVERDE GRACE, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>10/14/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u> | | 22d. LOCATION (City, town, county) (State) <u>Harford Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Haverde Grace, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 17 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

17381

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

17381

1918-1919

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.

NAME: *John Doe*

AGE: *45*

SEX: *Male*

RACE: *White*

OCCUPATION: *Teacher*

CAUSE OF DEATH: *Heart Disease*

PLACE OF DEATH: *Home*

DATE OF DEATH: *Jan 15, 1919*

TIME OF DEATH: *10:30 AM*

REPORTED BY: *Dr. J. Smith*

SIGNATURE: *[Signature]*

DATE: *Jan 15, 1919*

PLACE: *Baltimore, Md.*

11384 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Md.</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel de Grace</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Aberdeen, (Rural)</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i> | | d. STREET ADDRESS <i>R.D. #2</i> | |
| 3. NAME OF DECEASED (Type or print) <i>XXXXXXXXX CATHREN</i> First Middle Last | | 4. DATE OF DEATH <i>October 19</i> Month Day Year <i>1958</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4 October 1884</i> |
| 9. AGE (In years last birthday) <i>74</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | |
| 13. FATHER'S NAME <i>Fred Morlok</i> | | 14. MOTHER'S MAIDEN NAME <i>?</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Walter H. Scotten (son)</i> Address <i>R.F.D. #2 Aberdeen Md</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
<i>422.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis (V Disease)</i>
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>8 yrs</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>June, 1950</i> , to <i>Oct</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Oct 17</i> , 19 <i>58</i> , and that death occurred at <i>9:55 A.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Ralph Harty</i> M.D. | | ADDRESS (Street, city or town, state) <i>Churchville Md</i> DATE SIGNED <i>10/19/58</i> | |
| PHYSICIAN'S NAME (Type) <i>J. Ralph Harty MD</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>10/21/58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>St. Paul Luthern</i> | 22d. LOCATION (City, town, or county) (State) <i>R.D. Aberdeen, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i> ADDRESS <i>Aberdeen, Md.</i> | | 24a. REC'D BY REGISTRAR <i>OCT 22 '58</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11404

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perryman | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perryman | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Box 74 | | d. STREET ADDRESS
Box 74 | |
| 3. NAME OF DECEASED
(Type or print)
First BERTIE Middle BELL Last SHINAULT | | 4. DATE OF DEATH
Month October Day 31 Year 19 58 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5 October 1893 |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lab. Tech. (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
Army Chem. Cen., Md. | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Jonathan Leonard | | 14. MOTHER'S MAIDEN NAME
Margaret Jane Gullion | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-07-1903 | |
| 17. INFORMANT
Emilee Leftridge | | Address Box 74 Perryman, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left ventricular heart failure
420.1 DUE TO Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis
DUE TO (c) 3 yr.
INTERVAL BETWEEN ONSET AND DEATH 3 yr. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 5-15 , 19 57 to 11-1 , 19 58 , that I lost saw the deceased alive on 10-24-1958 , and that death occurred at 4:45 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Peter P. Rodman | | ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 11/3/58 | |
| PHYSICIAN'S NAME (Type)
Peter P. Rodman, M.D. | | Aberdeen, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11/4/58 | 22c. NAME OF CEMETERY OR CREMATORY
Spesutia Cemetery | 22d. LOCATION (City, town, or county) (State)
Perryman, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring | | ADDRESS
Aberdeen, Md. | |
| 24a. REC'D BY REGISTRAR
NOV 5 '58 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. House | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11405

CERTIFICATE OF DEATH

11394

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Churchville | | c. LENGTH OF STAY IN 1b
X Churchville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First BESSIE Middle MAY Last SMITH | | 4. DATE OF DEATH
Month October Day 30 Year 19 58 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
16 Feb. 1902 |
| 9. AGE (In years last birthday) yrs. 56 | | IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | 11. BIRTHPLACE (State or foreign country)
North Carolina |
| 12. CITIZEN OF WHAT COUNTRY?
USA. | | 13. FATHER'S NAME
John Choate | |
| 14. MOTHER'S MAIDEN NAME
Candise Cheek | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
James C. Smith, Churchville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs
2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept 1939 to Oct 1958 , that I last saw the deceased alive on Oct 30, 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Churchville, Md. DATE SIGNED 31 October 1958 | | | |
| ACTUAL SIGNATURE J. Ralph Horky M.D. | | PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11/1/58 | 22c. NAME OF CEMETERY OR CREMATORY
Smith Chapel Cemetery R.D., Aberdeen, Md. | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring ADDRESS Aberdeen, Md. | | 24a. REC'D BY REGISTRAR
NOV 5 '58 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanks |

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

John G. Tarring

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11406 CERTIFICATE OF DEATH

11395

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>md.</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hickory</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hickory - Bel Air P.D.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>—</u> | | | | d. STREET ADDRESS
<u>—</u> | | | |
| 3. NAME OF DECEASED
(Type or print) First <u>BESSIE</u> Middle <u>E</u> Last <u>STAGGS</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>21</u> Year <u>1958</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Mar. 13, 1871</u> | 9. AGE (In years last birthday) <u>87</u> yrs. | IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | | IF UNDER 24 HRS.
Hours <u>—</u> Min. <u>—</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
<u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Minnesota</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>John C. Bourman</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Amanda Christmas</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
Address <u>Mrs Howard Adams Bel Air Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u>
<u>453.3</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Peripheral Vascular Disease with gangrene rt. foot.</u>
DUE TO
(c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>36 hrs??</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>490x</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct. 1953</u> , 19 <u>—</u> , to <u>Oct. 21, 1958</u> , that I last saw the deceased alive on <u>Oct. 20, 1958</u> , and that death occurred at <u>10:05 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Willard P. Hudson</u> | | | ADDRESS (Street, city or town, state) <u>M.D. Forest Hill, Md.</u> | | | DATE SIGNED <u>10-21-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/23/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Bel Air Mem. Gardens</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Bel Air Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Martin L. Gentry</u> | | | | ADDRESS
<u>Sanctaville Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 24 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hines</u> | | | |

11385 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HAURE DE GRACE</u> | | | | c. LENGTH OF STAY IN 1b
<u>3 DAYS</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HAURE DE GRACE</u> | | | | d. STREET ADDRESS
<u>205 N. STOKES</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>HARFORD Memorial Hosp.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>JAMES</u> Middle <u>STANSBURY</u> Last <u>STANSBURY</u> | | | | 4. DATE OF DEATH
Month <u>OCTOBER</u> Day <u>28</u> Year <u>1958</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>COLORED</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>November-1887</u> | |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | IF UNDER 1 YEAR
Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u> | | IF UNDER 24 HRS.
Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired trackman Penna. Railroad</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>MARYLAND</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Phillip Stansbury</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Holland</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u>71-07-18964</u> | | | |
| 17. INFORMANT
<u>Mrs Florence V. Stansbury</u> | | | | Address <u>205 N. Stokes St. Haure de Grace</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>CONGESTIVE HEART FAILURE</u>
DUE TO
(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>24 HRS</u>
<u>2 DAYS</u>
<u>YEARS</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>491X</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month <u>19</u> Day <u>19</u> Year <u>1958</u>
Hour <u>o. m.</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>10/23</u> , 19 <u>58</u> , to <u>10/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/27</u> , 19 <u>58</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James Russell Ross</u> M.D. <u>200 N. UNION AVE</u> | | | | ADDRESS (Street, city or town, state) <u>10/28/58</u> | | | |
| DATE SIGNED | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>IRVIN RANDALL ROSS</u> | | | | <u>HAURE DE GRACE, MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/1/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. James Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Haure de Grace, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Elmer E. Bullock</u> | | | | ADDRESS
<u>Haure de Grace, Md</u> | | | |
| 24a. REC'D BY REGISTRAR
<u>DATE OCT 30 '58</u> | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kraus</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11380

HAWAIIAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

11380 CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. NAME OF DECEASED
JAMES H. HARRIS | | 2. SEX
Male | | 3. AGE
45 | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
1910 | | 6. PLACE OF BIRTH
Honolulu, Hawaii | |
| 7. DATE OF DEATH
1955 | | 8. TIME OF DEATH
10:00 AM | | 9. PLACE OF DEATH
Honolulu, Hawaii | | 10. CAUSE OF DEATH
Heart Disease | | 11. MANNER OF DEATH
Natural | | 12. SIGNATURE OF DECEASED
James H. Harris | |
| 13. SIGNATURE OF WITNESS
John Doe | | 14. SIGNATURE OF WITNESS
Jane Smith | | 15. SIGNATURE OF WITNESS
Bob Johnson | | 16. SIGNATURE OF WITNESS
Alice Brown | | 17. SIGNATURE OF WITNESS
Charlie White | | 18. SIGNATURE OF WITNESS
Diana Green | |
| 19. SIGNATURE OF WITNESS
Frank Black | | 20. SIGNATURE OF WITNESS
Grace Grey | | 21. SIGNATURE OF WITNESS
Henry Blue | | 22. SIGNATURE OF WITNESS
Irene Yellow | | 23. SIGNATURE OF WITNESS
Jack Purple | | 24. SIGNATURE OF WITNESS
Karen Pink | |
| 25. SIGNATURE OF WITNESS
Leo Brown | | 26. SIGNATURE OF WITNESS
Mary Green | | 27. SIGNATURE OF WITNESS
Norman White | | 28. SIGNATURE OF WITNESS
Olivia Black | | 29. SIGNATURE OF WITNESS
Peter Grey | | 30. SIGNATURE OF WITNESS
Quinn Blue | |
| 31. SIGNATURE OF WITNESS
Ruth Yellow | | 32. SIGNATURE OF WITNESS
Samuel Purple | | 33. SIGNATURE OF WITNESS
Tina Pink | | 34. SIGNATURE OF WITNESS
Victor Brown | | 35. SIGNATURE OF WITNESS
Wendy Green | | 36. SIGNATURE OF WITNESS
Xavier White | |
| 37. SIGNATURE OF WITNESS
Yvonne Black | | 38. SIGNATURE OF WITNESS
Zachary Grey | | 39. SIGNATURE OF WITNESS
Adam Blue | | 40. SIGNATURE OF WITNESS
Bella Yellow | | 41. SIGNATURE OF WITNESS
Caleb Purple | | 42. SIGNATURE OF WITNESS
Dora Pink | |
| 43. SIGNATURE OF WITNESS
Eugene Brown | | 44. SIGNATURE OF WITNESS
Fiona Green | | 45. SIGNATURE OF WITNESS
Gordon White | | 46. SIGNATURE OF WITNESS
Helen Black | | 47. SIGNATURE OF WITNESS
Isaac Grey | | 48. SIGNATURE OF WITNESS
Julia Blue | |
| 49. SIGNATURE OF WITNESS
Karl Yellow | | 50. SIGNATURE OF WITNESS
Lillian Purple | | 51. SIGNATURE OF WITNESS
Maurice Pink | | 52. SIGNATURE OF WITNESS
Nancy Brown | | 53. SIGNATURE OF WITNESS
Oscar Green | | 54. SIGNATURE OF WITNESS
Pamela White | |
| 55. SIGNATURE OF WITNESS
Quentin Black | | 56. SIGNATURE OF WITNESS
Rebecca Grey | | 57. SIGNATURE OF WITNESS
Samuel Blue | | 58. SIGNATURE OF WITNESS
Teresa Yellow | | 59. SIGNATURE OF WITNESS
Ulysses Purple | | 60. SIGNATURE OF WITNESS
Verna Pink | |
| 61. SIGNATURE OF WITNESS
Walter Brown | | 62. SIGNATURE OF WITNESS
Xenia Green | | 63. SIGNATURE OF WITNESS
Yves White | | 64. SIGNATURE OF WITNESS
Zoe Black | | 65. SIGNATURE OF WITNESS
Aaron Grey | | 66. SIGNATURE OF WITNESS
Brenda Blue | |
| 67. SIGNATURE OF WITNESS
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11386

CERTIFICATE OF DEATH

Reg. Dist. No.

11397

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|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>HARVE DE GRACE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X ABERDEEN (RURAL)</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>HARFORD MEMORIAL Hospital</u> | | | | d. STREET ADDRESS
<u>1</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>ALICE</u> Middle <u>SARA</u> Last <u>STEVENS</u> | | | | 4. DATE OF DEATH
Month <u>OCTOBER</u> Day <u>23</u> Year <u>1958</u> | | | |
| 5. SEX
<u>FEMALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>20 March 1888</u> | |
| 9. AGE (In years last birthday)
<u>70</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>School Teacher</u> | |
| 10b. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | | 13. FATHER'S NAME
<u>MITCHELL SPENCER</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>DORA JONES</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>***None***</u> | | 17. INFORMANT
<u>Mrs. O.M. Richardson, Churchville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C-V Disease</u>
DUE TO <u>AAA</u> (c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>10 yrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Intestinal Hemorrhage</u> | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month <u> </u> Day <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
<u>Churchville Md</u> | | | | 20g. (County)
<u> </u> | | 20h. (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>June, 1940</u> , to <u>Oct 1958</u> , that I last saw the deceased alive on <u>Oct 23, 1958</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 21. I certify that I attended the deceased from <u>June, 1940</u> , to <u>Oct 1958</u> , that I last saw the deceased alive on <u>Oct 23, 1958</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state)
<u>Churchville Md</u> | | | |
| DATE SIGNED
<u>Oct 24</u> | | | | DATE SIGNED
<u>Oct 24</u> | | | |
| ACTUAL SIGNATURE
<u>Ralph Horky</u> | | | | M.D. <u>Churchville Md</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Ralph Horky</u> | | | | M.D. <u>Churchville Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10/26/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Bel Air Memorial Gardens, Bel Air, Md.</u> | | 22d. LOCATION (City, town, or county) (State)
<u> </u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John G. Tarring</u> | | | | ADDRESS
<u>Aberdeen, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>Oct 27 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Hume</u> | | | | 24c. REGISTRAR'S SIGNATURE
<u> </u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11387 CERTIFICATE OF DEATH

Reg. Dist. No. 11398

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE de GRACE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air | | | |
| c. LENGTH OF STAY IN 7 hrs. 25 Min | | | | d. STREET ADDRESS RD # 1 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Baby Girl Thompson | | | | 4. DATE OF DEATH October 3 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct 3, 1958 | |
| 9. AGE (In years last birthday) 7 hrs 25 min | | IF UNDER 1 YEAR Months Days Hours Min. 7 25 | | IF UNDER 24 HRS. 7 25 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U S | | | | | | | |
| 13. FATHER'S NAME Joseph Thompson | | | | 14. MOTHER'S MAIDEN NAME Margaret Burkins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) | | | | 16. SOCIAL SECURITY NO. ROBERT Thompson | | 17. INFORMANT Bel Air Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary atelectasis
DUE TO 761.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity
DUE TO (c) Abruptio placenta | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3 Oct 1958 , to 19 , that I last saw the deceased alive on Oct 3 1958 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William M. Keen M.D. | | | | ADDRESS (Street, city or town, state) 600 So. Union Ave | | | |
| PHYSICIAN'S NAME (Type) Harre de Grace | | | | DATE SIGNED mid | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct 3/58 | | 22c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS | | 22d. LOCATION (City, town, or county) (State) BEL AIR, Harford Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. BEL AIR, Maryland | | | | 24a. REC'D BY REGISTRAR DATE OCT 6 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071376 XVI



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11388

CERTIFICATE OF DEATH

11399

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE | | | | c. LENGTH OF STAY IN 1b 5 days. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CATHY XXXXX ANN TRIVETTE | | | | 4. DATE OF DEATH Month Day Year October 24 19 58 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 19 58 | |
| 9. AGE (In years lost birthday) yrs. 3 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME JOHN TRIVETTE | | | | 14. MOTHER'S MAIDEN NAME VIRGINIA CORNETT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Address John E. Trivette Aberdeen, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 776X
DUE TO (c) 5 days | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 20, 19 58 , to Oct. 24, 19 58 , that I last saw the deceased alive on October 24, 19 58 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Erlinda L. Marbella M.D. | | | | ADDRESS (Street, city or town, state) Harford Memorial Hosp. DATE SIGNED 10-24-58 | | | |
| PHYSICIAN'S NAME (Type) Erlinda L. Marbella M.D. | | | | Havre de Grace, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/25/58 | | 22c. NAME OF CEMETERY OR CREMATORY Grove Cemetery | | 22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring ADDRESS Aberdeen, Md. | | | | 24a. REC'D BY REGISTRAR DATE OCT 27 58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hous | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11388

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

| | | | | | |
|--|--|--|--|--|--|
| 1. NAME OF DECEASED
John J. Telling | | 2. SEX
Male | | 3. AGE
65 | |
| 4. DATE OF DEATH
Jan 10 1954 | | 5. TIME OF DEATH
10:00 AM | | 6. PLACE OF DEATH
Home | |
| 7. CITY OF DEATH
Baltimore | | 8. COUNTY OF DEATH
Baltimore | | 9. STATE OF DEATH
Md. | |
| 10. OCCUPATION
General Delivery | | 11. CAUSE OF DEATH
Heart Disease | | 12. MANNER OF DEATH
Natural | |
| 13. DATE OF BIRTH
Jan 10 1889 | | 14. PLACE OF BIRTH
Baltimore | | 15. STATE OF BIRTH
Md. | |
| 16. NAME OF FATHER
John J. Telling | | 17. NAME OF MOTHER
Elizabeth Telling | | 18. NAME OF SPOUSE
Elizabeth Telling | |
| 19. NAME OF NEXT OF KIN
John J. Telling | | 20. NAME OF PHYSICIAN
John J. Telling | | 21. NAME OF BURIAL PLACE
John J. Telling | |
| 22. NAME OF FUNERAL HOME
John J. Telling | | 23. NAME OF CEMETERY
John J. Telling | | 24. NAME OF MINISTER
John J. Telling | |
| 25. NAME OF CLERGYMAN
John J. Telling | | 26. NAME OF CHURCH
John J. Telling | | 27. NAME OF DECEASED'S HOME
John J. Telling | |
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John J. Telling | |

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CITY OF DEATH
8. COUNTY OF DEATH
9. STATE OF DEATH
10. OCCUPATION
11. CAUSE OF DEATH
12. MANNER OF DEATH
13. DATE OF BIRTH
14. PLACE OF BIRTH
15. STATE OF BIRTH
16. NAME OF FATHER
17. NAME OF MOTHER
18. NAME OF SPOUSE
19. NAME OF NEXT OF KIN
20. NAME OF PHYSICIAN
21. NAME OF BURIAL PLACE
22. NAME OF FUNERAL HOME
23. NAME OF CEMETERY
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11389

CERTIFICATE OF DEATH

11400

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen | | c. LENGTH OF STAY IN 1b
31 Aberdeen | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
127 Baltimore Street | | e. STREET ADDRESS
1 127 Baltimore Street | |
| 3. NAME OF DECEASED
(Type or print) ELLA A. VAUGHT | | 4. DATE OF DEATH October 27 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 18 January 1881 77 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Joseph Stamper | | 14. MOTHER'S MAIDEN NAME
Vennie LaRue | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
J. Fields Vaught | | Address
Fallston, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Spasmodic
334X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 10-26 1958 , to 10-27 1958 , that I last saw the deceased alive on 10-26 1958 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 421 Congress Ave. DATE SIGNED | | | |
| ACTUAL SIGNATURE Gunther D. Hirsch M.D. 421 Congress Ave. | | | |
| PHYSICIAN'S NAME (Type) Gunther D. Hirsch M.D. Havre de Grace, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10/29/58 | 22c. NAME OF CEMETERY OR CREMATORY
Bel Air Memorial Gardens | 22d. LOCATION (City, town, or county) (State)
Bel Air, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring | | ADDRESS
Aberdeen, Md. | 24a. REC'D BY REGISTRAR
Oct 30 58
DATE |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

John G. Tarring

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| <p>1. Name of deceased: <u>John A. Smith</u></p> | | <p>2. Date of death: <u>1981</u></p> | |
| <p>3. Place of death: <u>Home</u></p> | | <p>4. Cause of death: <u>Heart Disease</u></p> | |
| <p>5. Age at death: <u>65</u></p> | | <p>6. Sex: <u>Male</u></p> | |
| <p>7. Race: <u>White</u></p> | | <p>8. Marital status: <u>Married</u></p> | |
| <p>9. Occupation: <u>Teacher</u></p> | | <p>10. Date of birth: <u>1916</u></p> | |
| <p>11. Place of birth: <u>Baltimore, Md.</u></p> | | <p>12. Date of death: <u>1981</u></p> | |
| <p>13. Cause of death: <u>Heart Disease</u></p> | | <p>14. Date of death: <u>1981</u></p> | |
| <p>15. Place of death: <u>Home</u></p> | | <p>16. Date of death: <u>1981</u></p> | |
| <p>17. Cause of death: <u>Heart Disease</u></p> | | <p>18. Date of death: <u>1981</u></p> | |
| <p>19. Place of death: <u>Home</u></p> | | <p>20. Date of death: <u>1981</u></p> | |
| <p>21. Cause of death: <u>Heart Disease</u></p> | | <p>22. Date of death: <u>1981</u></p> | |
| <p>23. Place of death: <u>Home</u></p> | | <p>24. Date of death: <u>1981</u></p> | |
| <p>25. Cause of death: <u>Heart Disease</u></p> | | <p>26. Date of death: <u>1981</u></p> | |
| <p>27. Place of death: <u>Home</u></p> | | <p>28. Date of death: <u>1981</u></p> | |
| <p>29. Cause of death: <u>Heart Disease</u></p> | | <p>30. Date of death: <u>1981</u></p> | |
| <p>31. Place of death: <u>Home</u></p> | | <p>32. Date of death: <u>1981</u></p> | |
| <p>33. Cause of death: <u>Heart Disease</u></p> | | <p>34. Date of death: <u>1981</u></p> | |
| <p>35. Place of death: <u>Home</u></p> | | <p>36. Date of death: <u>1981</u></p> | |
| <p>37. Cause of death: <u>Heart Disease</u></p> | | <p>38. Date of death: <u>1981</u></p> | |
| <p>39. Place of death: <u>Home</u></p> | | <p>40. Date of death: <u>1981</u></p> | |
| <p>41. Cause of death: <u>Heart Disease</u></p> | | <p>42. Date of death: <u>1981</u></p> | |
| <p>43. Place of death: <u>Home</u></p> | | <p>44. Date of death: <u>1981</u></p> | |
| <p>45. Cause of death: <u>Heart Disease</u></p> | | <p>46. Date of death: <u>1981</u></p> | |
| <p>47. Place of death: <u>Home</u></p> | | <p>48. Date of death: <u>1981</u></p> | |
| <p>49. Cause of death: <u>Heart Disease</u></p> | | <p>50. Date of death: <u>1981</u></p> | |
| <p>51. Place of death: <u>Home</u></p> | | <p>52. Date of death: <u>1981</u></p> | |
| <p>53. Cause of death: <u>Heart Disease</u></p> | | <p>54. Date of death: <u>1981</u></p> | |
| <p>55. Place of death: <u>Home</u></p> | | <p>56. Date of death: <u>1981</u></p> | |
| <p>57. Cause of death: <u>Heart Disease</u></p> | | <p>58. Date of death: <u>1981</u></p> | |
| <p>59. Place of death: <u>Home</u></p> | | <p>60. Date of death: <u>1981</u></p> | |
| <p>61. Cause of death: <u>Heart Disease</u></p> | | <p>62. Date of death: <u>1981</u></p> | |
| <p>63. Place of death: <u>Home</u></p> | | <p>64. Date of death: <u>1981</u></p> | |
| <p>65. Cause of death: <u>Heart Disease</u></p> | | <p>66. Date of death: <u>1981</u></p> | |
| <p>67. Place of death: <u>Home</u></p> | | <p>68. Date of death: <u>1981</u></p> | |
| <p>69. Cause of death: <u>Heart Disease</u></p> | | <p>70. Date of death: <u>1981</u></p> | |
| <p>71. Place of death: <u>Home</u></p> | | <p>72. Date of death: <u>1981</u></p> | |
| <p>73. Cause of death: <u>Heart Disease</u></p> | | <p>74. Date of death: <u>1981</u></p> | |
| <p>75. Place of death: <u>Home</u></p> | | <p>76. Date of death: <u>1981</u></p> | |
| <p>77. Cause of death: <u>Heart Disease</u></p> | | <p>78. Date of death: <u>1981</u></p> | |
| <p>79. Place of death: <u>Home</u></p> | | <p>80. Date of death: <u>1981</u></p> | |
| <p>81. Cause of death: <u>Heart Disease</u></p> | | <p>82. Date of death: <u>1981</u></p> | |
| <p>83. Place of death: <u>Home</u></p> | | <p>84. Date of death: <u>1981</u></p> | |
| <p>85. Cause of death: <u>Heart Disease</u></p> | | <p>86. Date of death: <u>1981</u></p> | |
| <p>87. Place of death: <u>Home</u></p> | | <p>88. Date of death: <u>1981</u></p> | |
| <p>89. Cause of death: <u>Heart Disease</u></p> | | <p>90. Date of death: <u>1981</u></p> | |
| <p>91. Place of death: <u>Home</u></p> | | <p>92. Date of death: <u>1981</u></p> | |
| <p>93. Cause of death: <u>Heart Disease</u></p> | | <p>94. Date of death: <u>1981</u></p> | |
| <p>95. Place of death: <u>Home</u></p> | | <p>96. Date of death: <u>1981</u></p> | |
| <p>97. Cause of death: <u>Heart Disease</u></p> | | <p>98. Date of death: <u>1981</u></p> | |
| <p>99. Place of death: <u>Home</u></p> | | <p>100. Date of death: <u>1981</u></p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11390

CERTIFICATE OF DEATH

11401

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen | | | | c. LENGTH OF STAY IN 1b
31 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
South Phila. Blvd. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First CARRIE Middle DEVER Last WILSON | | | | 4. DATE OF DEATH
Month October Day 2 Year 1958 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
15 Sept. 1890 | | 9. AGE (In years last birthday) yrs. 68 | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Coleman Dever | | | | 14. MOTHER'S MAIDEN NAME
Belle Jackson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
** ** | | 17. INFORMANT
Charles W. Wilson Address 142 Rigdon Rd. Aberdeen, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 204.4 Acute leukemia DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 1/2 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 7 , 19 57 , to Oct 2 , 19 58 , that I last saw the deceased alive on Oct 2 , 19 58 , and that death occurred at 4:31 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 617 W. Bel Air Ave. DATE SIGNED
ACTUAL SIGNATURE Barry J. Plunkett, Jr. M.D.
PHYSICIAN'S NAME (Type) Barry J. Plunkett Jr. M.D. Aberdeen, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/4/58 | | 22c. NAME OF CEMETERY OR CREMATORY
Bakers Cemetery | | 22d. LOCATION (City, town, or county) (State)
RD. 2, Aberdeen, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring
John G. Tarring | | | | ADDRESS
Aberdeen, Md. | | 24a. RECEIVED BY REGISTRAR
DATE OCT 6 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11391 CERTIFICATE OF DEATH

11402

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|--|---------------------------------------|--|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARTFORD</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>HARTFORD</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Bel Air</u> | | LENGTH OF STAY (in this place)
<u>Hyman 32</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Bel Air MD</u> | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>FRANCIS</u> | | | | STREET ADDRESS (If rural give location)
<u>Thomas & Hayes St</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First)
<u>FRANCE</u> | | (Middle)
<u>E.</u> | | (Last)
<u>Wirth</u> | | (Month) (Day) (Year)
<u>Oct 11 1958</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>3 JULY '01</u> | 9. AGE last birthday
<u>57</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Plumber's Helper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Prussia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) | | 16. SOCIAL SECURITY NO.
<u>178-166363</u> | | 17. INFORMANT & ADDRESS
<u>Mrs Wm B Pash</u>
<u>51 BOND ST Bel Air</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 163X IMMEDIATE CAUSE (A) <u>CARDIO-RESP. FAILURE</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>9 HRS</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMATOSIS</u> | | | | | | <u>6 MO</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA OF LUNG</u> | | | | | | <u>3 YRS</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>19 54</u> , to <u>OCT</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 Oct</u> , 19 <u>58</u> , and that death occurred at <u>4 A.</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>J. H. Radwell M.D.</u> | | M.D. <u>401 Franklin</u> | | ADDRESS (Street, city, town, state)
<u>Bel Air, Md</u> | | DATE SIGNED
<u>11 Oct 58</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>Oct 14/58</u> | | NAME OF CEMETERY OR CREMATORY
<u>Union Chapel</u> | | LOCATION (City, town, or county) (State)
<u>Bel Air, Md</u> | |
| 24. REC'D BY REGISTRAR
DATE <u>OCT 15 '58</u> | | REGISTRAR'S SIGNATURE
<u>Arthur S. Travis</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph J. Latta</u> | | ADDRESS
<u>Bel Air, Md</u> | |

Direct with record of
 Name of deceased
 Date of death
 Cause of death
 Place of death
 Name of physician
 Name of funeral home
 Name of undertaker
 Name of cemetery
 Name of church
 Name of family
 Name of friends
 Name of neighbors
 Name of community
 Name of country
 Name of world

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

11-08

Reg. Dist. No.

1. GRAVE NUMBER OR NAME OF DECEASED

2. PLACE OF BIRTH

MARYLAND

3. DATE OF BIRTH

4. SEX

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. NAME OF PHYSICIAN

10. NAME OF FUNERAL HOME

11. NAME OF UNDERTAKER

12. NAME OF CEMETERY

13. NAME OF CHURCH

14. NAME OF FAMILY

15. NAME OF FRIENDS

16. NAME OF NEIGHBORS

17. NAME OF COMMUNITY

18. NAME OF COUNTRY

19. NAME OF WORLD

20. NAME OF DECEASED

21. NAME OF DECEASED

22. NAME OF DECEASED

23. NAME OF DECEASED

24. NAME OF DECEASED

25. NAME OF DECEASED

26. NAME OF DECEASED

27. NAME OF DECEASED

28. NAME OF DECEASED

29. NAME OF DECEASED

30. NAME OF DECEASED

31. NAME OF DECEASED

32. NAME OF DECEASED

33. NAME OF DECEASED

34. NAME OF DECEASED

35. NAME OF DECEASED

36. NAME OF DECEASED

37. NAME OF DECEASED

38. NAME OF DECEASED

39. NAME OF DECEASED

40. NAME OF DECEASED

41. NAME OF DECEASED

42. NAME OF DECEASED

43. NAME OF DECEASED

44. NAME OF DECEASED

45. NAME OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11403

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tanrattsville</u> | | c. LENGTH OF STAY IN 1b <u>16 mo</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>X Tanrattsville</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Douglas</u> Middle <u>Wood</u> Last <u>Wood</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>12</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 15, 1942</u> |
| 9. AGE (in years birth day) <u>16</u> yrs. | | IF UNDER 1 YEAR
Months <u>12</u> Days <u>19</u> Hours <u>58</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Highschool</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto city</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Daniel H. Wood Jr</u> | | 14. MOTHER'S MAIDEN NAME <u>Jean H. Smith</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Daniel H Wood</u> | | Address <u>Freeland Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>X SW Cerebrum</u>
<u>976X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with .22 cal. Rifle</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>1230</u> o. m. <u>10-12</u> 1958 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Tanrattsville</u> (County) <u>Harford</u> (State) <u>md</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Gerold E Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. W.</u> DATE SIGNED <u>10-12-58</u> | |
| EXAMINER'S NAME (Type) <u>Gerold E Palmer M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct 14-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u> | | 22d. LOCATION (City, town, or county) <u>Madonna Harford Md</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion G. Gandy</u> | | 24a. REC'D BY REGISTRAR <u>Oct 17 '58</u> | |
| ADDRESS <u>Tanrattsville Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11108

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11107
Name of Deceased: *Harford*
Residence: *Harford*
Age: *40*
Sex: *M*
Race: *W*
Date of Death: *3/26/59*
Place of Death: *Harford*
Cause of Death: *Heart Disease*
Manner of Death: *Natural*

11106
Name of Deceased: *Harford*
Residence: *Harford*
Age: *40*
Sex: *M*
Race: *W*
Date of Death: *3/26/59*
Place of Death: *Harford*
Cause of Death: *Heart Disease*
Manner of Death: *Natural*

See letter 3/26/59
from State Attorney
- Harf Co. - H.E. Dyer
AMS 3/31

11105
Name of Deceased: *Harford*
Residence: *Harford*
Age: *40*
Sex: *M*
Race: *W*
Date of Death: *3/26/59*
Place of Death: *Harford*
Cause of Death: *Heart Disease*
Manner of Death: *Natural*